SAVE

Financial Agreement & Appointment Reminders

a. I acknowledge that as a courtesy, MySpectrum Counseling & Coaching may bill my insurance company for services provided to me
b. I agree to pay for services that are not covered, or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductibles, or charges not covered by insurance. I also understand that there is a $15 charge for not making a copay at the time of my appointment and that a 1.5 percent charge will be added to my bill for each month a statement is mailed.
c. I understand that there is a $50 fee for returned checks.
d. I understand that if I do not show up for an appointment without calling or if I cancel on the same day of my appointment, my credit card or account will incur a $55 fee. Appointments must be canceled 48 hours in advance to avoid a charge. _____**(Initial)**
E. If I arrive 15 minutes late for my appointment, I understand that my therapist will not be able to see me, I will be charged a No Show fee of $55, and I will have to reschedule my appointment. _____**(Initial)**

Third Party Collections
e. I acknowledge that MySpectrum Counseling & Coaching may utilize the services of a third-party business associate or affiliated entity as an extended business office (EBO Service) for medical billing and servicing. _____ **(Initial)**

Assignment of Benefits
f. I hereby assign to, MySpectrum Counseling & Coaching any insurance or other third-party benefits available for health care services, provided to me. I understand, MySpectrum Counseling & Coaching has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to MySpectrum Coaching & Coaching, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt. _____ **(Initial)**

Medicare Patient Certification and Assignment of Benefit.
g. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to MySpectrum Counseling & Coaching, by the Medicare and Medicaid programs. _____ **(Initial)**

Consent to Telephone Calls for Financial Communications.
h. I agree that, in order for, MySpectrum Counseling & Coaching, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that, MySpectrum Counseling & Coaching or EBO Servicers and collection agents may contact me by telephone at any telephone number, without limitation to wireless, I have provided or, MySpectrum Counseling & Coaching or EBO Servicers and collection agents have obtained or at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of

contact may include using pre-recording/artificial voice messages and/or use of an automatic dialing service, as applicable. _____ **(Initial)**

Appointment Notifications

i. I hereby agree to allow MySpectrum Counseling & Coaching contact me regarding upcoming appointment reminders via the following methods:

_☐_ Email
_☐_ Telephone (including voice message)
_☐_ Text Message (data rates may apply)
_☐_ Any of the above
_☐_ None of the above

MySpectrum Fee Schedule

Initial Intake Assessment (60 minutes)	$175
Therapy Session (45-50 minutes)	$120
Therapy Session (60 minutes)	$145
Family Therapy (w/client)	$145
Family Session (w/o client)	$145
Interactive Complexity Add On	$120
Group Therapy	$40.00

Mental Health Evaluation for Court, Lawyers (does not include fee for writing a report)	$250
Outside Office Work (Inpatient visits, Collaborative Services, Court appearances, etc.)	$100 per hour
Written Report (Court, Supervisors)	$100 per hour
Consultation	$100 for non client $75 for current client

No Show/Late Cancellation Fee (less than 24 hour notice	$55
Returned Check Fee - per check	$50

A photocopy of this consent shall be considered as valid as the original. _____ **(Initial)**

_____

Patient/Representative Signature **Date**

If you are not the patient, please identify your Relationship to the patient _____